DOCUMENT RESUME

ED 300 831 CS 211 591

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TITLE Medical Documentation: A Composition Concern for Now and the Nineties.
PUB DATE Feb 88
NOTE 14p.; Paper presented at the Annual Meeting of the Southeast Regional Conference on English in the Two-Year College (Louisville, KY, February 18-20, 1988).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Charts; Medical Case Histories; *Nursing Education; Postsecondary Education; Two Year Colleges; Writing (Composition); *Writing Instruction; Writing Skills
IDENTIFIERS *Medical Documentation; Medical Records; Writing Contexts

ABSTRACT

Medical documentation is a form of writing rich with possibilities for composition instructors, for example, for instructors in two-year colleges teaching writing skills to practical nursing students. It is also a form of writing which could benefit dramatically from the application of recent composition research. Few medical documentation texts exist; most medical documentation learning takes place in clinical experience or on the job. Poor medical documentation can be dangerous, costly, and have legal ramifications since a patient's medical record constitutes a legal document. Critical observation is crucial to good medical documentation (especially in charting). Composition instructors already teach many of the same critical thinking skills that medical documentation requires. Close attention to the recording skills most useful to nurses would offer much the same improvement that research has provided composition instruction. (A selected annotated bibliography of 5 books and 12 articles on the subject is appended.) (SR)

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SCETC Presentation: 1988

Medical Documentation

A Composition Concern for Now and the Nineties

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As a two-year college English professor researching medical literature for writing skills material to teach practical nursing students, I have in the past several years experienced a consciousness raising with regard to medical documentation. My reading in recent nursing literature, such as a 1984 Focus on Critical Thinking article entitled "Improving Documentation Through the Use of Change Theory" (article 5 on the attached bibliography), has introduced me to change theory, the process through which one effects smooth, successful change. The first step involves convincing the target audience that it needs to change. I want to take that first step here by sharing the process by which I convinced myself that medical documentation is a worthy current and future composition concern for writing researchers and instructors. This process of awareness has developed in three stages.

In the first stage, I learned that few medical documentation texts exist, none that suited my particular purpose, and that most medical documentation learning takes place in clinical experience or on the job. Several years ago, as a two-year

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college English professor assigned a vocational-technical practical nursing course in communication skills for the first time, I searched for a text. Numerous standard technical writing texts could provide the required job application skills as well as incident reporting and, with some variation on giving instructions, patient teaching. Medical documentation, however, posed a problem.

My text search provided few clues.

Attending a 1984 Winter Workshop of the Georgia State Vocational/Technical Allied Health instructors, I surveyed seventy-five practical nursing instructors, asking among other things the titles of their texts. None had a text devoted to charting primarily; usually, if they used anything it was the physical assessment list or Subjective/Objective/Assessment/Plan. As I look back over my accumulated bibliography I find only one book available in 1982, Ceccio and Ceccio's Effective Communication in Nursing: Theory and Practice(fourth book listed), and I did not locate it at that time. I wish that I had. "Written by a specialized writing teacher and a nursing staff development educator," as its Preface explains, it gives excellent guidelines for different types of documentation and would have offered me valuable direction even though I would have discovered limitations, such as little observation instruction and fact/inference analysis.

The text that has proved most valuable for my purposes was

Schneller and Godwin's Writing Skills for Nurses: A practical Text/Workbook (1983)(see book 2).It combines writing instruction and workbook exercises, especially in charting, including situations for timed charting.

Continuing my search for information that would instruct me in how to teach medical documentation, especially charting or nurses' notes, I again turned to nurses for their experience. Attendance at the North Carolina Mountain Area Nurses Education Association meeting in 1987 provided opportunity to survey nurses, this time asking how they learned to chart in their training. Overall, the responses meant "in clinical" or, in other words, on the job. When they left their nursing classroom for experience in the hospitals, they began charting, having been prepared most often by oral instruction only. None listed having had time practice writing sessions in class. Such crisis learning seems typical in nurses I have questioned, a situation which possibly explains, at least in part, some of the repeated answers to my continual question, "How do you feel about charting": "I'd rather be shot than chart"; "Charting is a necessary nuisance"; "Patient care takes precedence over medical documentation"; "I already know what I'm going to chart before I go in the room"; "How do I say something when there's nothing to say?" Such attitudes suggest attitudes that might be improved by a good text with classroom instruction.

During my ongoing search for a text, I discovered problems

associated with poor medical documentation, especially charting or nurses' notes. This served as the next stage in my developing awareness. Local resources, such as the director of staff development at the local hospital, informed me and my classes through illustrated talks that a patient's medical record constituted a legal document that required objective, factual information, concise presentation, and clear expression of a patient's daily care. The English teacher in me felt the relief of recognition in learning that the old familiar code words, "objective," "factual," "concise," "clear," constituted problem areas for medical documentation as I already knew they did for English compositon.

As a member of the local hospital's crisis management committee, the staff development director also alerted my class and me to the dangerous and costly results as well as the legal ramifications associated with poor charting caused by these problem areas. A review of available nursing journals supported her claims. There I found medical documentation a long-standing and continuing problem. Each year yielded articles regarding some aspect of inadequate charting. Practical nursing instructor Judy Dent directed me to one of the most useful, "Charting: How and Why to Document Your Care Daily--and Fully"(first article listed). The most common complaint lamented that adequate to excellent medical care goes undocumented.

Three articles in the attached bibliograpy represent the kind

of documentation problems. In article five, for instance, Gawlinski and Rasmussen show that charting in their hospital's critical care unit failed to reflect the nursing process provided. In article seven, "Get It in Writing," Pauline Gay discusses charting deficiencies that did not reflect the high quality of care given at Bay Harbor Hospital, California. In article eight, Mary Laing discusses a "retrospective chart audit" that revealed very poor nursing documentation at Royal Inland Hospital in Kamloops, B.C. Each article suggested different methods of improving charting quality. Now I had some idea of what "medical documentation" meant as well as evidence that it was a problem.

Now that I knew something about the situation surrounding medical documentation instruction and about recurring problems in medical documentation, I sorted my information looking for possible solutions to minimize instructional difficulties and maximize student learning. The third stage in my increasing awareness concerned learning the crucial role of critical observation in the process of charting. My personal physician provided the key to this stage during a routine physical examination when I included him in my survey, "What skill do you most appreciate in a nurse?" His answer was observation because her acute and accurate perception could save him time, money, and mistakes. When I asked the best way to teach observation, he dismissed the possibility. "Either she's got it or she doesn't,"

he declared.

Having heard in the past conventional academic wisdom that writing could not be taught yet knowing the current research and success in that endeavor, I looked for effective ways to do that. Treating writing as a process had contributed significantly to progress in teaching writing. The same, I thought, might be true of medical documentation. If medical documentation were viewed as a process, then observation would be the first stage in that process as in writing.

Several nursing texts do mention observation, sometimes giving it the emphasis of several pages of discussion; although usually in relation to interpersonal relations, the references do indicate an increase in attention paid to observation. A 1987 article in Nursing Outlook, "Teaching Students Observational Skills" (see article 11), is the first I have located that addresses an issue which must be a common problem, the need for more a scientific observation system.

One text suggested to me a means of teaching critical observation, something English composition instructors do to a greater or lesser extent in all of their writing courses. Thomas W. Muldary's Interpersonal Relations for Health Professionals: A Social Skills Approach (see book 5) taught me about recent research in the process of perception. I discovered that I could apply to medical documentation what Muldary related to social

skills. For instance, in discussing organizing sensory information as the second stage of the process of perception, Muldary mentions an organizational principle he calls "closure," the one that Nurse Bevin found most instructive for herself when I shared my material with her. "Closure" refers to the brain's tendency to complete sensory information even when the material necessary for completion remains unknown. If a person sees a drawing of a horse's head, for instance, in his mind he completes the entire figure of the horse. This principle of organization can lead a person to leap to conclusions based on incomplete evidence. Awareness of such a problem in the observatonal process can alert a viewer to view more carefully, to verify his conclusions, to recheck a scene, or, in other words, to observe critically.

Nurse Bevin said that after reading about closure she caught herself over and over depending upon closure to complete her observations. Recognition of her dependence shocked her into more critical awareness.

Moving on to the next possible stage of observation, fact/inference analysis, a quick check of the available texts discussing charting will show that each states that charting relies upon objective fact, yet each one assumes that fact/inference analysis requires either no or little explanation, not to mention examples and exercises, for the student to grasp the distinction fully. Gandolf and Roman's The Nurse's Writing

Handbook, in many ways a very fine text, barely mentions distinguishing between fact and inference. Schneller and Godwin's Writing Skills for Nurses offers only one page of explanation and no exercises on defining and distinguishing facts and inferences. Along with critical observation, more careful fact/inference differentiation could contribute not only to better charting but also to overall critical thinking.

The increased emphasis on critical thinking in nursing practices would respond to the medical profession's own assessment of notable inadequacy. A 1985 issue of Journal of Professional Nursing includes the article "New Directions in Higher Education: A Review of Trends"(see article 12). The authors review six significant reports published from 1982 to 1985 on the quality of education in the United States, including two which focus on medical training: 1) Needed: A New Way to Train Doctors. The President's Report t the Harvard Board of Overseers for 1982-83;; and 2) Physicians for the Twenty-first Century: The GPEP Report. Report of the Panel on the General Professional Education of the Physician and College Preparation, Association of American Medical Colleges. Two conclusions drawn from the review concern increased emphasis on intellectual skills such as analytic and critical thinking skills.

Muldary's text suggested to me a way to teach critical observation, something English instructors do to a greater or lesser degree in basic composition courses. In fact,

composition instructors already teach many of the same critical thinking skills medical documentation would require. Close attention to the recording skills most useful to nurses would offer much the same improvement that research has provided composition instruction. The productive combination of writing instructors and nurses appears in such writing/nursing teams as Joseph F. Ceccio and Cathy M. Ceccio in Effective Communication in Nursing: Theory and Practice(see book 4).

The stages in my evaluation of teaching medical documentation brought me to the realization that this area represents a writing concern rich with possibilities for composition instuctors. This is a form of writing that could benefit dramatically from application of recent compsition research. I pass on to you the awareness that my research provided. Now is a good time for a change in composition instructors' awareness, for medical documentation is a worthy composition concern for now and the nineties.

A Selected Bibliography

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Books

1. Gandolfo, Anita, and Judy Romano. The Nurse's Writing Handbook. Norwalk, Connecticut: Appleton-Century-Crofts, 1984.

A fine compact book which divides its contents into two parts: the first part emphasizes the writing process and the second part discusses the process in practice. Designed as a "self-contained, comprehensive program in writing instruction"(Preface) in a single volume, this book does a good job of concentrating on typical writing experiences for the student and professional nurse, but what it gains in breadth it necessarily lose in depth so that that limit themselves to a maximum of four brief examples and provide no exercises. The authors explain the absence of exercises by saying that the student will learn more from exercising the text's writing instruction in writing assignments for their nursing courses:"It is designed for self-motivated learners who would like to improve their skill in written communication as well as for instructors who want skill in written communication as well as for instructors who want to provide instruction in writing for their students without taking time from nursing instruction"(Preface).

2. Schneller, Trudy, and Christine Godwin. Writing Skills for Nurses: A Practical Text/Workbook. Reston, Virginia: Reston Publishing Company, Inc., 1983.

A very good combination of writing instruction and workbook exercises, especially in charting, including situations for timed charting. Covers nurse's progress notes, other patient-care forms, problem-oriented records, computer-assisted documentation, and special situations, such as incident reports, memos, and job application letters/resumes. Very useful. No mention of observation. One page and no exercises on defining/distinguishing facts/inferences/opinions.

3. Van Hoozer, Helen, Lavonne Ruther, and Martha Craft. 11 Introduction to Charting. Philadelphia, PA: J. B. Lippincott Co., 1982.
This brief text covers only charting as a writing skill, including good, lengthy background information on charting, its purposes and importance. It provides sufficient illustrations and exercises with answers for immediate feedback. Particularly useful is its list of "Common Descriptive Terms." Nursing students often chart poorly because they lack pertinent vocabulary of common usage rather than medical vocabulary. Does not cover observation or distinguishing between fact/inference/opinion.

4. Ceccio, Joseph F., and Cathy M. Ceccio. Effective Communication in Nursing: Theory and Practice. New York: John Wiley and Sons, 1982.
"Written by a specialized writing teacher and a nursing staff development educator, [this book] aims at (1) preparing professional nursing students to handle the many writing and speaking tasks they will encounter on the job and (2) helping people already working in the profession to communicate more effectively" (Preface). Excellent guidelines for different types of documentation. No extensive exercises, little emphasis on observation, fact/inference analysis.

5. Muldary, Thomas W. Interpersonal Relations for Health Professionals: A Social Skills Approach. New York: Macmillan Publishing co., Inc., 1983.
A most useful text in applying the process of perception to social interaction in the medical environment.

Articles

1. Eggland, Ellen Thomas, RN,MN. "Charting: How and why to Document Your Care Daily--and Fully." Nursing 80 February 1980: 39-43.
This review of charting purposes and skills contains practical suggestions for avoiding illustrated charting problems as well as a list of terms to describe signs and symptoms and a list of do's and don't's.

2. Holloway, Vonicha McClenny, RN,BSN,MBA. "Documentation: One of the Ultimate Challenges in Home Health Care." Home Healthcare Nurse January/February 1984: 19-22.
Poor documentation can cause even excellent skilled care to remain unreimbursed.

3. Sklar, Corinne. "Negligence in the Hospital Labaor Room: A Tragic Lesson for All Concerned." The Canadian Nurse. January 1982:48-50.
Included in the You and the Law magazine section, this case history records a legal suit against a hospital which developed in part because of inadequate, inaccurate, and

questionable information in both the charting records and the incident reports.

4. Suhayda, Rosemarie, RN,MSN, and Mi Ja Kim, RN, PhD, FAAN. "Documentation: A Vital Link to Nursing Practice." Focus on Critical Care April 1985, 12(2): 58-59.
Based on a previous study documenting failures in critical care record keeping, these authors sought reasons, finding: 1) evolving nature of nursing which obscures boundaries of practice in collaboration with other health professionals; 2) inadequate time so that procedural or technical duties take precedence; 3) nurses' attitude that patient care takes precedence over documentation; 4) charting methods which provide no appropriate mechanism for recording nursing judgments and actions; 5) nurses failure to see long-term implications of recording practices, such as the connection between documentation and credibility as a profession.

5. Gawlinski, Anna, RN,MSN,CCRN, and Sherri Rasmussen, RN,MN, CCRN. "Improving Documentation Through the Use of Change Theory." Focus on Critical Care. December 1994, 11(6): 12-17.
The authors establish that CCU charting in their hospital failed to reflect the nursing process; they propose problem-oriented medical records as a possible solution and record the steps in the process of changing from conventional narrative charting to POMR.

6. Groah, Linda, RN, and Elizabeth A. Reed, RN. "Your Responsibility in Documenting Care." AORN Journal May 1983, 37(6): 1174 - 1182.
"Documentation is a matter of professional survival"(1174). Reviews good documentation techniques that will help prevent criminal indictment in case of a crisis.

7. Gay, Pauline, BA,RN. "Get It in Writing." Nursing Management March 1983, 14(3): 32 - 35.
Nursing documentation at Bay Harbor Hospital, California, did not reflect the high quality of care given. The article records the steps taken to improve documentation, including graphs reflecting decreases in specific deficiencies.

8. Laing, Mary. "Flow Sheets: Meeting the Charting Challenge." The Canadian Nurse. December 1981: 40 - 42.
A "restrospective chart audit" at Royal Inland Hospital in Kamloops, B.C., revealed very poor nursing documentation; they chose to develop flow charts to improve documentation.

9. Horsley, Jack E., JD. "Charting Nasty Truths with an Absence of Malice." RN July 1983: 16.
The best way to communicate negative character information about patients, given the expectation that the patient may very well read the information at some point, is to follow

the rules of evidence: chart ASAP, confine notes to 13 observations, no matter how "unpalatable or seemingly insignificant."

10. Katz, Barbara F., J. D. "Reporting and Review of Patient Care: The Nurse's Responsibility." Law, Medicine, and Health Care April 1983: 76-79.
"Nursing staffs need policies and procedures to guide their actions in situations where patient welfare is endangered by physicians or other hospital staff. It needs to be emphasized to nurses, as well as to all health care personnel, that reporting substandard care is a legitimate nursing function"(79).

11. Hogstel, Mildred O. "Teaching Students Observational Skills." Nursing Outlook March/April 1987: 89-91.
Beginning with a distinction between inspection and the more difficult general observational skills, Hogstel makes an effort to fill the need for a more scientific observation system, offering suggestions for classroom content, teaching techniques, and practice in clinical. This is the only recent article this researcher has found that addresses an issue which must be a common problem.

12. Sakalys, Jurate, and Jean Watson. "New Directions in Higher Education: A Review of Trends." Journal of Professional Nursing September-October 1985: 293-299.
The authors review six significant reports published from 1982 to 1985 on the quality of education in the United States, including two which focus on medical training: 1) Needed: A New Way to Train Doctors. The President's Report to the Harvard Board of Overseers for 1982-83; 2) Physicians for the Twenty-first Century: The GPEP Report. Report of the Panel on the General Professional Education of the Physician and College Preparation, Association of American Medical Colleges. Two conclusions drawn from the review concern increased emphasis on the liberal arts and intellectual skills, such as analytic, problem-solving, and critical thinking skills.